RMD Bulletin

Knowledge is power…

Community Partners Must Capture UMDAP Information on the PFI

The State Department of Mental Health, under Welfare and Institutions Code (WIC) Sections 5709 and 5710 and California Code of Regulations (CCR), Title 9, Division 1, Subchapter 3, Article 3, Section 524 mandates that all clients be financially screened when receiving specialty mental health services through County Mental Health Plans. As part of the financial screening procedure, specialty mental health providers are required to employ the Uniform Method of Determining Ability to Pay (UMDAP) when assessing the client's/payer's ability to personally pay for mental health services rendered. The Payer Financial Information (PFI) form is used by the County of Los Angeles Department of Mental Health to financially screen clients, identifying and documenting third party payer sources for billing purposes, and to apply the UMDAP process. The UMDAP process not only determines the client's ability to pay but it also establishes the client's annual charge period which lasts one year. Both the annual charge period and the annual liability determined by UMDAP must be honored by specialty mental health providers statewide.

Revenue Management Division (RMD) has created the attached version of the PFI exclusively for use by Community Partners. Fields or boxes not directly applicable to clients seen by Community Partners have been shaded out. To use this new version, Community Partners should transfer the relevant client information from the Department of Health Services (DHS) Ability-To-Pay (ATP) income form used for financial screening to the PFI at the very first visit when clinically appropriate then staple the ATP form to the back of the PFI. This even applies to clients receiving emergency services. Remember, the annual liability for HWLA clients is $0.00 and the client should not be charged for services. A copy of the financial screening documents should be provided to the client if referred to another DMH provider for treatment.

We're here to help you…

If you have any questions or require further information, please do not hesitate to contact RMD at (213) 480-3444 or via e-mail at RevenueManagement@dmh.lacounty.gov.

DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

HWLA PAYER FINANCIAL INFORMATION FOR CPs

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME		SS #	DMH CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE NAME

THIRD PARTY INFORMATION

3	NO THIRD PARTY PAYER ☐							
4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL COUNTY CODE /AID CODE/ CIN #		MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ASSESSMENT ☐ YES ☐ NO			DATE REFERRED	
5	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON			
6	CALWORKS ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN #	AB3632 ☐ YES ☐ NO	AB3632 CONSENT FORM SIGNED ☐ YES ☐ NO		
7	MEDICARE ☐ YES ☐ NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	HEALTHY WAY LA ☐ YES ☐ NO	HWLA MEMBER #
8	HMO/PPO ☐ YES ☐ NO	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED		
9	CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO		

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYER	RELATION TO CLIENT	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	PAYER CDL/CAL ID	
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #	
12	SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: _____				PAYER SS #	
13	EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED	
14	EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #	
15	SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #	
16	SPOUSE'S EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED	
17	SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #	
18	NEAREST RELATIVE/RELATIONSHIP	ADDRESS (Include City, State & Zip Code)			TEL #	

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS

Savings	$_____
Checking Accounts	$_____
IRA, CD, Market value of stocks, bonds and mutual funds	$_____
TOTAL LIQUID ASSETS	$_____
Less Asset Allowance	$_____
Net Asset Valuation	$_____
Monthly Asset Valuation (Divide Net Asset by 12)	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

20 ALLOWABLE EXPENSES

Court ordered obligations paid monthly	$_____
Monthly child care payments (necessary for employment)	$_____
Monthly dependent support payments	$_____
Monthly medical expense payments	$_____
Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$_____
Total Allowable Expenses	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

21 ADJUSTED MONTHLY INCOME

Gross Monthly Family Income	
Self/Payer	$_____
Spouse	$_____
Other	$_____
TOTAL HOUSEHOLD INCOME	$_____
TOTAL FROM BOX 19	$_____ +
SUBTOTAL	$_____
LESS TOTAL FROM BOX 20	$_____ -
Adjusted Monthly Income	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

22	Number Dependent on Adjusted Monthly Income (Client included)	**ANNUAL LIABILITY**	**ANNUAL CHARGE PERIOD** FROM TO
	Payment Plan $_____ per month for 1 2 3 4 months.		
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)		

OTHER

24	PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		DATE	